

DeKalb Township, 2323 S. 4<sup>th</sup> Street, P.O. Box 504, DeKalb, IL. 60115  
PHONE: (815) 758-8282 FAX: (815) 758-0124

APPLICATION FOR ADMISSION TO:  
DEKALB COUNTY REHAB AND NURSING CENTER  
2660 North Annie Glidden, DeKalb, Il. 60115

APPLICANT INFORMATION:

TOWNSHIP: DEKALB

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_  
STREET CITY STATE ZIP CODE

PHONE: \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_  
Length of Residency at this address \_\_\_\_\_

Please complete: (If you have not resided at the above address for 2 yrs., please complete the following.)

Previous Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Previous Address: \_\_\_\_\_ From \_\_\_\_\_ To \_\_\_\_\_

Type of Payment: Medicare \_\_\_\_\_ Private \_\_\_\_\_ Public Aid \_\_\_\_\_

Reason for placement or other comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_  
(Applicant, Family Member or other person completing this form)

Date: \_\_\_\_\_

**PLEASE COMPLETE THE CONTACT NAMES ON THE BACK OF THIS FORM. PLEASE PRINT CLEARLY. COMPLETE IN BLUE OR BLACK INK. THANK YOU.**

1) Please provide as many telephone numbers as possible for each Contact Person. We will call every number listed for each person. Due to time restraints we do not leave messages on recorder. If we are unable to reach any of the Contact Person(s), we will place application at the bottom of the list and move on to the next application.

2) When our office calls the Contact Person, we require a response. Please advise Contact Person(s) to respond with an affirmative answer if placement is desired. Attach additional sheet if more than two contact people will be used.

APPL.CH

OVER

